



How to Select The Health Coverage that is Right for You



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WHO WE ARE AND HOW WE CAN HELP CONSUMERS



WHO WE ARE AND HOW WE CAN HELP CONSUMERS

The Maryland Insurance Administration is the State Agency that regulates the business of insurance in the State of Maryland. If you are having a problem related to insurance, the MIA will try to help you to solve that problem.

How We Help Consumers

We provide assistance to consumers, businesses, health care providers (doctors, hospitals), and producers (agent or broker) in all areas of insurance, including life, health, disability, automobile, homeowners, and property.

- We can provide you with answers to your general insurance questions and suggest actions or procedures that you may wish to take to help resolve insurance problems.
- We can provide you with educational material (such as homeowners and automobile consumer guides) to help you to understand rights and obligations that you may have with respect to various types of insurance policies and what to consider and question when you are shopping for insurance.
- We can provide you with guides that can help you to compare rates among insurers writing automobile, homeowners, health coverage for small employers, and for Medicare supplement policies.
- We can investigate any circumstance within our jurisdiction that you bring to our attention in writing to make certain that companies and individuals who are engaged in the business of insurance in our State obey Maryland laws and regulations.
- We can investigate written allegations that your insurance carrier, insurance producer (agent), or another entity engaged in the business of insurance:
 - did not pay or authorize the payment for medically necessary services;
 - has improperly denied or delayed payment of all or some portion of your claim;
 - has improperly terminated your insurance policy;
 - has improperly raised your insurance premiums;
 - has made false statements to you in connection with the sale of insurance or the processing of insurance claims;
 - overcharged you for services, including premium finance charges.

Resources for Consumers

The MIA produces consumer guides, rate comparisons and frequently asked questions related to various types of insurance. The following is a sample list of available publications:

- Consumer Guide to Homeowner Insurance
- Consumer Guide to Automobile Insurance
- Health Carriers for Small Employers
- Annual Premiums for Medicare Supplement Policies

You can access this information in several ways:

- Download it from our web site, www.mdinsurance.state.md.us, on the *Consumer Publications* page.
- Call or write the agency to have copies mailed to you.
- Visit our display at any number of community events around the State.
- Find these printed materials at various state and local agencies.

HOW TO SELECT THE HEALTH COVERAGE THAT IS RIGHT FOR YOU



HOW TO SELECT THE HEALTH COVERAGE THAT IS RIGHT FOR YOU

What Options are Available to Maryland Consumers To Pay for Medical Care

With the rising costs of medical care, consumers are more carefully considering ways to pay for their health care. While many employers still offer some form of health benefits, frequently employees are purchasing additional coverage to fill in gaps, or they are purchasing all of their medical coverage. The purpose of this section of the brochure is to give consumers an overview of what options are available and to help them know what questions to ask when they are making purchasing decisions. **The most important point is to read your plan documents carefully and make certain that you understand all of the rules.**

What Is Available

A. Group Health Plans – A group health plan is generally offered by your employer. If your employer offers health coverage to all of its employees, then it may not refuse to offer this coverage to you based on a condition in your medical history. [An employer may refuse to provide you with coverage for another reason, i.e. you are a part-time employee and coverage is not given to any part-time employee.]

Employers may offer different types of health plans. These plans can be provided by insurers, non-profit health service plans or health maintenance organizations (HMOs).

The insurer and non-profit health service plans can be divided into two categories – Traditional Major Medical and Preferred Provider Organization Plans:

1. **Traditional Major Medical Plans** – This type of policy is designed to cover and reimburse medical expenses such as hospitalization, doctor visits, surgery, diagnostic tests and prescription drugs. Traditional major medical policies usually require insureds to satisfy out-of-pocket deductibles and coinsurance provisions. These plans allow insureds to obtain medical treatment from the doctor or hospital of their choice. Benefits are typically based on Usual, Customary and Reasonable (UCR) charges. These plans generally limit the insured's annual out-of-pocket expenses. A limit is also placed on the amount of benefits payable over the insured's lifetime (e.g., \$1 million, \$5 million and \$10 million lifetime maximum).
2. **Preferred Provider Organization (PPO) Plans** – Insurers that offer PPO plans contract with physicians, hospitals and other health care providers who agree to provide health care services at a discounted rate. PPO plan members may obtain care from a doctor or a hospital that is not a preferred provider if they are willing to pay additional out-of-pocket expenses. In some PPO plans, members may see specialists without any prior referral or authorization. However, some plans are more restrictive and require a referral before seeing a specialist.
3. **Health Maintenance Organizations (HMOs)** – Your employer may also offer care through a Health Maintenance Organization (HMO). HMOs sell "open panel" and "closed panel" type plans. Under a closed panel plan, the HMO generally requires members to use only certain providers under contract with the health plan. Exceptions are given for emergencies or while the member is outside the service area. Members select a primary care provider from the list of contracted providers and pay a co-payment for medical care. Members must also receive authorization from the primary care provider before they can see specialists who are also in the network. The HMO may deny coverage under the closed panel plan if care is delivered by an out-of-network provider.

HMO “open panel” plans are similar to PPO plans offered by insurers and nonprofit health service plans in that members have a choice of receiving care from both in-network providers and out-of-network providers. When the HMO member chooses an out-of-network provider, the member generally pays more out-of-pocket than if the member were to see an in-network provider. These higher out-of-pocket costs can come in the form of higher copayments, coinsurance and deductibles.

In addition to these plans, your employer may also offer coverage for specific illnesses (i.e. cancer), specific types of treatment (i.e. dental), treatment in a specific place (i.e. hospital), or treatment for a specific event (i.e. accident or disability). The most important thing to remember is when choosing a plan, make certain that it fits your needs and you can afford it. See our tips on choosing a health plan to help you make the right choice.

B. Small Employer Health Plans – Small employers have fewer than 50 eligible employees and are covered by the Comprehensive Standard Health Benefit Plan. This Plan has benefits determined by the Maryland Health Care Commission. The details of those benefits are found in *A Guide to Purchasing Health Insurance for Small Employers*, which can be found at www.mhcc.state.md.us or by contacting the Maryland Health Care Commission at:

4160 Patterson Avenue
Baltimore, Maryland 21215
(410) 764-3460
(877) 245-1762

You may also obtain this information by contacting us at:

525 Saint Paul Place
Baltimore, Maryland 21202
(410) 468-2000
(800) 492-6116
www.mdinsurance.state.md.us

C. Individual Health Plans – This is health insurance sold to one person or all the members of one family under one policy. Individual coverage is usually purchased when a person’s employer does not offer health insurance or the person wishes to supplement an existing policy. Consumers purchase individual health insurance directly from a health plan of their choice. Most of the plans that are available to groups are also available to individuals; however, an insurer that sells an individual policy is permitted to refuse to offer you a policy because of your health status. You and your family members must be in very good health to qualify. When you fill out the application, you must be as thorough as possible in answering the questions. If the insurer finds out later that you had a medical condition that you did not tell them about on the application, they can take back the money that they have paid on your behalf, leaving you with unpaid claims.

D. Maryland Health Insurance Plan (MHIP) – If you are denied an individual policy for health reasons, you can enroll in the Maryland Health Insurance Plan (MHIP). This is a plan administered by the State to provide coverage to people seeking HIPAA coverage and those who have been denied a medically underwritten policy. You may also qualify if you have certain medical conditions. These are several coverage options, all of which require a premium payment. Their phone number is (866) 780-7105. Their web site is www.marylandhealthinsuranceplan.state.md.us.

E. Medical Discount Plans – Discount plans may be structured to look like insurance, but they are not insurance and are not regulated by the Maryland Insurance Administration. Certain plans may be marketed in conjunction with some types of insurance coverage, such as accidental death or disability. If you question whether something is a discount plan or insurance, contact the Maryland Insurance Administration at (800) 492-6116.

Discount plans offer savings on various goods and services, i.e. prescription drugs, doctors visits, eye glasses, vision care, dental services, lab tests, etc. For a fee (either monthly or yearly) the “plan member” is entitled to receive services or goods from a specific doctor or pharmacy at a discounted price. For more information go to our web site at www.mdinsurance.state.md.us.

F. Health Savings Accounts (HSAs) – Health Savings Accounts were created by H. R. 1, the “Medicare Prescription Drug, Improvement and Modernization Act of 2003,” signed into law by President Bush on December 8, 2003 and are designed to help individuals save for future qualified medical and retiree health expenses on a tax-free basis. New innovative Health Savings Accounts will change the way millions can save to meet their health care needs.

Any individual who is covered by a high-deductible health plan may establish an HSA. Amounts contributed to an HSA belong to individuals and are completely portable. Every year the money not spent would stay in the account and gain interest tax-free, just like an IRA. Unused amounts remain available for later years. Tax-advantaged contributions can be made in three ways: the individual and family members can make tax deductible contributions to the HSA even if the individual does not itemize deductions; the individual’s employer can make contributions that are not taxed to either the employer or the employee; and employers with cafeteria plans can allow employees to contribute untaxed salary through a salary reduction plan. Funds distributed from the HSA are not taxed if they are used to pay qualifying medical expenses. To encourage saving for health expenses after retirement, HSA owners between age 55 and 65 are allowed to make additional catch-up contributions (\$500 in 2005) to their HSAs. Individuals eligible for Medicare today may not open an HSA. To learn more about HSAs, contact the United States Department of the Treasury at:

United States Department of the Treasury
Office of the Executive Secretary
1500 Pennsylvania Avenue, NW
Washington, D.C. 20220
Telephone: (202) 622-2000
Fax: (202) 622-6415
www.ustreas.gov

G. Self-Funded / Self-Insured – Some employers and labor unions provide group health benefits coverage for their employees or members through self-funded plan arrangements. Employers who choose to self-insure employee health plan benefits are responsible for payment of claim liabilities and performing certain administrative functions ordinarily transferred to an insurance company under fully insured health insurance plans. Most often, self-insured plan sponsors contract with insurance companies or third party administrators (TPAs) to provide administrative services; however, the employer or plan sponsor is ultimately responsible for seeing that claims are paid in accordance with plan provisions and ensuring the plan is properly administered.

The Maryland Insurance Administration does not regulate self-insured, single-employer plans as they are not subject to state insurance laws. Single employer and union sponsored self-funded health plans are regulated by the U.S. Department of Labor’s Pension and Welfare Benefits Administration under the guidelines of the Employees’ Retirement Income Security Act (ERISA) of 1974.

H. COBRA / Maryland Continuation Coverage – In addition to the types of plans listed above, if you are leaving your job, have just been involuntarily terminated from your job, have recently been divorced or your spouse has died, you may be able to obtain coverage under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA) or under Maryland’s continuation coverage laws. For more information, please refer to Section D of this brochure.



Questions to Ask When Shopping for Health Care Coverage

When you are shopping for health care coverage, (whether it is offered by your employer or if you are purchasing it on your own), it is important that you understand exactly what you are buying, the cost of what you are buying and whether you can afford the plan, and if it provides you with the services that you need. The following are some questions that will help you when you are comparing different plans:

1. Is this an insurance policy or a discount plan?
[For information about medical discount plans, see Section B-1 of this brochure as well as our brochure entitled "Discount Medical and Prescription Plans."]
2. Is the insurance company licensed to sell insurance in Maryland?
[Check our web site at www.mdinsurance.state.md.us.]
3. Is the producer (agent or broker) licensed?
[Call us at (410) 468-2000 or (800) 492-6116.]
4. Is this a plan offered through a trade association? If yes, you are required to pay membership dues in addition to your premium. Do the dues continue after you no longer want health coverage under the plan? Is the plan issued in Maryland? If not, the Maryland Insurance Administration may not be able to assist you with any problems.
5. How much does the health coverage cost?
6. Will the rates increase? If so, how often?
7. Do you pay a charge to receive health care? What is it? Is the charge dependent on the services you receive and where you receive the services?
8. Is there a deductible? If so, how often? How much is it?
9. Are there any limits on how much you must pay for health care services you receive (out-of-pocket maximums)?
10. Are there any limits on the number of times you may receive a service (lifetime maximums or annual benefit caps)?
11. Does the plan have a deductible amount for each insured person? (That is, the amount each person must pay out-of-pocket before benefits will be paid.)
12. Is there a separate deductible for some services, such as maternity?
13. Are there separate co-pays for some services?
 - Doctor office visits.
 - Use of emergency room if not admitted to a hospital.
14. Does the plan have different benefit levels if I use an in-network/participating provider or an out-of-network/nonparticipating provider? How easy is it to get a list of participating providers? Are my doctors, medical facilities, or pharmacies included as participating providers? How easy is it to find a local participating/in-network provider? You may want to ask your doctor directly if he or she would accept this insurance for your care.

15. Does the plan require pre-authorization, pre-certification for some procedures and/or referrals from a primary care physician? Are there penalties if I don't pre-authorize or pre-certify treatment? Who do I contact to obtain pre-authorization or pre-certification?
16. What services does the health coverage include?
17. What services does the health coverage exclude?
18. Will the health coverage pay for preventative care, maternity care, well-baby care, substance abuse treatment, organ transplants, vision care, dental care, infertility treatment, durable medical equipment, or chiropractic care? Does Maryland law require the carrier (the term 'carrier' includes insurers, HMOs and non-profit health plans) to cover certain benefits? To learn more about what benefits are required under Maryland law, see Section C of this brochure.
19. Will the plan pay for prescriptions?
20. What happens when I call the company's customer service number? Can I reach a real person to answer my questions?
21. What happens if I am outside of Maryland or the U.S. and need emergency care?
22. Has my doctor, pharmacist, or health provider had any problems with this carrier in submitting claims for other insureds?
23. Are there waiting periods before certain illnesses are covered? Are there any other limitations on coverage of certain illnesses?
24. What are the renewal conditions? Under what circumstances can the carrier increase my premium?
25. How easily can I change primary-care physicians if I want to?
26. Do I need to get permission before I see a specialist?
27. Does the plan reimburse alternative medical therapies such as acupuncture or chiropractic treatment?

To learn more about the options available to cover your health care, see Section B-1 of this brochure.

Tips for Shopping for Health Care Coverage

1. Don't write a check, give out your bank account number or give any person money until you are completely sure that you understand exactly what coverage you are buying. Even if the person appears trustworthy, if you feel at all confused – wait. Give yourself as much time as you need to think about it. Ask for the business card of the individual selling you the policy. Also ask for all documents related to the policy and its benefits. Make sure you get a receipt when you do buy the policy. Read your policy and know where it is. Keep it in a safe location.
2. If you allow the insurance company to deduct payments directly from your bank account and you decide to end your insurance, it could take several months to stop the deductions and longer still to get back the money they continue to collect.
3. Find out if the product you are purchasing is an insurance policy, health maintenance organization (HMO) contract, a self-funded plan, or a medical discount plan. It is important that you understand what you are purchasing and the benefits being provided. To learn more about the different health care coverages available, refer to our publication "What Options are Available to Maryland Consumers to Pay for Medical Care" at www.mdinsurance.state.md.us.
4. Comparison shop. Request and read copies of the brochures describing the benefits and how to use them. For a list of companies selling individual health policies, HMO policies and small employer policies, visit our web site at www.mdinsurance.state.md.us.
5. Take the necessary time to learn all you can about the insurance you want to buy. Ask the opinion of people who you trust and enlist their help in your search. Is your doctor familiar with this carrier? (Throughout this document, the term "carrier" is used to include insurers, HMOs and non-profit health plans.) Get all the information you need to ensure you are comfortable with your decision.
6. Don't be afraid to ask questions. Never buy an insurance policy you do not understand.
7. Do not be misled by advertising. Only you can decide if a policy is the right one for you. Do not buy a policy simply because it is endorsed on television or radio, in newspapers or other advertisements by famous people.
8. Find out at the time you are applying for coverage if and under what circumstances a company can refuse to renew your policy.
9. Fill out your application completely and accurately. If you do not give correct and complete answers to all questions, your claims may be denied or your policy cancelled. If someone else fills out the application for you, read it carefully before signing it. When you sign an application, you are agreeing that it is correct and complete even if someone else has filled it in for you.
10. Be careful how you pay for the policies. It is best to pay by check, money order, or bank draft made out to the insurance carrier. If you pay cash, make sure you get a receipt.
11. Shop carefully. Policies differ widely in coverage and cost.
12. Read and understand the policy. Make sure it provides the kind of coverage that's right for you. You don't want unpleasant surprises when you're sick or in the hospital. If the policy doesn't seem to have the coverage you thought you had purchased, you should return it within ten days after you receive it. Most companies give you at least ten (10) days to look over your policy after you receive it. This means the policyholder has ten (10) days after receipt of the policy to decide if they want to keep it. Carriers are permitted to charge you for the period of time the policy was in effect.

13. Check to see that the policy states the date that the policy will begin providing coverage, what benefits are provided or excluded and what deductibles, copayments, coinsurance or out-of-pocket maximums apply.
14. There are some policies that offer protection for only one disease, such as cancer. If you have health insurance, your regular plan may already provide all the coverage you need. Check to see what protection you have before buying additional insurance.
15. All health plans have a section titled "Exclusions and Limitations." Such sections should be reviewed very carefully before you accept the policy. If a benefit or service is limited or excluded, you will not be covered even though treatment may be considered medically necessary.
16. Before an insurance company will accept you as a potential policyholder, the company may want to place an exclusionary rider on your policy for a specified condition. If the policy is issued with an exclusionary rider, you will be responsible for the cost of any medical care, including doctor visits, prescription drugs and emergency care services received for the treatment of the excluded condition. Under Maryland law, carriers are not permitted to exclude mandated benefits. For a list of mandated benefits, go to Section C-1 of this brochure, or visit our web site at www.mdinsurance.state.md.us.

Frequently Asked Questions:

What Is Open Enrollment? Can I Enroll In My Health Plan At Work After Open Enrollment?

Open enrollment is the term used to describe a period when you can join a health benefit plan without having to prove you are healthy. There is no State law regarding open enrollment periods. Most employers have an open enrollment period once a year. Typically, this is the only time when you may enroll in or make changes to your health benefit plan.

If you do not enroll, or you do not enroll your dependents during your employer's open enrollment period, and your circumstances later change, you may then be able to enroll. This is called a "special enrollment" period. Federal and State laws require a special enrollment period for certain specific reasons. If your employer provides family or dependent coverage, then you may have a special enrollment period if you gain an eligible dependent through marriage, birth, adoption, or placement for adoption. You must already be enrolled in the plan, or enroll at the same time as your new dependent. You usually must enroll within 31 days of the date of the marriage, birth, adoption, or placement for adoption.

If you or your dependent loses other health coverage, you may also be eligible for a special enrollment period if you meet the following requirements and request enrollment within 30 days of the event:

- You or your dependent was covered under another employer group health plan at the time coverage was offered to you at work.
- You gave a written statement turning down coverage because you had coverage elsewhere, but only if your employer or insurance company asked for a statement.
- Either the other coverage was under COBRA continuation laws, and the COBRA coverage has run out; or, you were no longer eligible for the other coverage.

Why Is Health Insurance So Expensive?

Over the last few years, the costs of health care have risen sharply. There are many reasons for this. The average age in America is rising. As the baby boomers age, there are more older people with a greater need for health care. Technology has improved, but has also become more expensive. Doctors and hospitals are raising their fees as their costs increase. Advertising has helped stir demand for new prescription drugs, and the new drugs can be much more expensive than drugs already on the market. As health carriers pay more for these treatments, they raise premiums to cover their costs.

The role of the Insurance Administration is to make sure that the insurance companies and HMOs charge enough premium to pay claims and remain in business, while also protecting consumers from increases that are too high. Our actuaries carefully review premium increases to make certain that the company can justify the amount of the increase. If health care costs are increasing, it unfortunately means that your premiums will also increase.

Health insurers and HMOs base their premiums, in part, on your age and geographic area. The areas around Baltimore and Washington have different cost factors associated with premiums than areas in Western Maryland or the Eastern Shore. If you have a small employer policy or an individual policy, you may find that your premiums go up sharply when your age or the group's age rises. Insurers and HMOs are not permitted to raise premiums for individuals or for small employers based on the claims of one person or based on the claims of the one employer group.

If your employer offers different health benefit options, or if you are purchasing a policy on your own, you should carefully consider how you use health care to select the best value for you. If you rarely go to the doctor, and have savings to cover a deductible, you may want to select a policy that will have a lower monthly premium, but high deductibles. If you

have a high-deductible policy, you may be able to use a health savings account to gain tax advantages. You should discuss this option with a trusted financial adviser or broker.

How Can I Find Individual Health Insurance?

If you are between jobs, leaving school, or starting your own business, you may find that you need an individual health insurance policy. You should consider your needs and budget carefully before applying for a policy. Policies offer different levels of coverage for different levels of premium. For some policies, you may have to prove that you are in good health. When a company reviews your health to determine if you can be insured, it is called medical underwriting.

The least expensive option for individual health insurance will be a medically underwritten policy. This option is the least expensive because insurance companies and HMOs are very selective about issuing these policies. You and your family members must be in very good health to qualify. When you fill out the application, you must be as thorough as possible in answering the questions. If the insurer finds out later that you had a medical condition that you did not tell them about on the application, they can take back the money that they have paid on your behalf, leaving you with unpaid claims. A list of carriers offering individual policies is available on the Insurance Administration's web site, www.mdinsurance.state.md.us or by calling us at (800) 492-6116.

If you are leaving a group policy, you may be eligible for continuation coverage under that policy. This means that you would still be a member of the group, but you would pay your entire premium yourself. You may also be able to convert your coverage to an individual policy that does not require medical underwriting. You should read your certificate of coverage or call the insurance company to learn the details of how to take advantage of one of these options.

If you are denied an individual policy for health reasons, you can enroll in the Maryland Health Insurance Plan (MHIP). This is a plan administered by the State to provide coverage to people seeking HIPAA coverage and those who have been denied a medically underwritten policy. You may also qualify if you have certain medical conditions. There are several coverage options, all of which require a premium payment. Their phone number is (866) 780-7105. Their web site is www.marylandhealthinsuranceplan.state.md.us.

Can A Newborn Be Added To My Health Plan And How Long Can My Child Stay On My Health Plan?

Maryland law allows you to add your new children to your group health plan even if you do not currently have coverage. This includes children born to you, children you adopt or children placed with you for adoption. It also includes children for whom you have custody and children for whom you are the grandparent or guardian. If you do not have coverage, you must enroll yourself at the same time you seek to enroll your new dependents. In most cases, you must tell the health plan about the new child and pay an extra premium within 31 days. If you already have family coverage, and no additional premium is required for the next child, you should still notify the plan within 31 days of the birth or adoption to avoid denied claims.

You have the right to keep your child on your health plan even after your child reaches the age limit set by your health plan if your child is not able to be self-supporting due to an incapacity; however, you will have to pay the cost to keep your child on your health plan. An example would be if your health plan contract states that coverage terminates when a child reaches 18, but your child is unable to support himself due to an incapacity. Your covered child can stay on your plan as long as the child is not married, mainly dependent on you and is incapacitated.

If you are unable to afford health care for your child, you should contact the Maryland

Medical Assistance Program. This program is responsible for providing access to health care services to low income residents of the State of Maryland. Services are provided through three programs – Maryland Medicaid Program, Maryland Children’s Health Program and Maryland Pharmacy Assistance Program. To find out more information, contact your local Department of Social Services or your local Health Department. You may also contact the DHMH Recipient

Relations Hotline at:
(410) 767-5800
(800) 492-5231
www.dhmf.state.md.us

Another option if you cannot afford health care for your child is the Maryland Medicaid Waiver Program. This program is responsible for the implementation and ongoing administration of home and community-based services waivers and target case management programs for special population groups. The Program studies, plans, and implements services relating to the needs of special populations such as the elderly, the mentally ill, and all physically and mentally disabled. To learn more about what is available under this program, and whether you are eligible for any waivers, contact your local Department of Social Services.

Can A Health Insurance Company Refuse To Give Me An Insurance Policy Because Of A Past Medical Condition?

If you have a history of a health problem, or if you have a health problem at the time you apply for health insurance, in certain circumstances an insurance company could either refuse to give you a policy or apply an exclusionary rider that excludes your health problem from coverage for a period of time. In some cases, the company may only issue a policy with a rider that permanently excludes the condition.

When you fill out the application, you must be as thorough as possible in answering the questions. If the insurer finds out later that you had a medical condition for which you sought treatment or if you have been diagnosed as having a medical condition that you did not tell them about on the application, they can take back the money that they have paid on your behalf, leaving you with unpaid claims.

*** The rules of whether you may be denied an insurance policy depend on the type of policy you are attempting to purchase:**

A. Group Health Plans – If your employer offers health coverage to all of its employees, then it may not refuse to offer this coverage to you based on a condition in your medical history. [An employer may refuse to provide you with coverage for another reason, i.e. you are a part-time employee and coverage is not given to any part-time employee.]

Even if you have a group health plan offered by a fully insured employer, there may be limitations on your coverage for preexisting conditions. The law permits an employer to have a 12-month waiting period before it is required to cover preexisting conditions. [If you join the health plan after you are hired and not during a regular or special enrollment period, the waiting period can be 18 months.] A carrier may only exclude a preexisting condition if it relates to a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the enrollment date.

Even if your employer has a waiting period, if you previously had continuous insurance coverage, you may be eligible for an offset of some or all of the waiting period. This is referred to as “creditable coverage.” You will need proof that you had health insurance coverage that was not interrupted by a break of 63 days in a row.

B. Small Employer Health Plans – A small employer health plan may not refuse to insure an employee based on a preexisting condition and it also may not place exclusions on the coverage. Moreover, the carrier may not charge a higher premium because of an employee's or dependent's health status. However, if the employee joins the health plan after his initial eligibility and not during a regular or special enrollment period, a 12-month waiting period may be imposed.

C. HMOs – HMOs are not allowed to impose preexisting condition exclusions. However, if you purchase an individual HMO plan, you may be turned down because of your health status.

D. Individual Health Plans – An insurer that sells an individual policy is permitted to refuse to offer you that policy because of health status. You and your family members must be in very good health to qualify. When you fill out the application, you must be as thorough as possible in answering the questions. If the insurer finds out later that you had a medical condition that you did not tell them about on the application, they can take back the money that they have paid on your behalf, leaving you with unpaid claims.

If you buy your individual plan from an HMO, then your preexisting condition **may not** be excluded.

If you are denied an individual policy for health reasons, you can enroll in the Maryland Health Insurance Plan (MHIP). This is a plan administered by the State to provide coverage to people seeking coverage from the Health Insurance Portability and Accountability Act (HIPAA) and those who have been denied a medically underwritten policy. You may also qualify if you have certain medical conditions. There are several options, all of which require a premium payment. Their phone number is (866) 780-7105. Their web site is www.marylandhealthinsuranceplan.state.md.us.

*** What you can do if you believe your health plan has improperly excluded coverage stating that it is an excluded preexisting condition:**

You should first file an appeal with the health plan. You should send a written letter of appeal; a telephone call may not be enough. You should carefully review your certificate of coverage or policy and the denial notice that was sent to you to learn how to file an appeal. You should file your appeal as soon as possible. Your appeal may be denied by the health plan if it is past their deadline for appeals. The Health Education and Advocacy Unit in the Office of the Attorney General may assist you in preparing your appeal. Their toll-free telephone number is (877) 261-8807, and their web site is www.oag.state.md.us. (Complaint forms are available online.) If you are covered by a health insurance or HMO policy issued in Maryland, you only need to file one appeal with the company.

After you have received an appeal decision, if you remain dissatisfied, and your coverage is subject to Maryland law, you may file a complaint with the Maryland Insurance Administration. Our web site, www.mdinsurance.state.md.us has both complaint forms and authorizations to release medical records that you may print out and send to us. You should include copies of the denial letters you received from the company and any other correspondence you have. For further assistance, our toll-free number is (800) 492-6116.

MARYLAND'S MANDATED BENEFITS



MARYLAND'S MANDATED BENEFITS

About This Section of the Brochure

Health insurers, HMOs and nonprofit health service plans are different types of companies that all offer health benefit plans. The term "carrier" or "health carrier" will be used to refer to them collectively. In some cases, a law will apply to only one or two of these types of companies, but not all three. Most laws will apply to all three. Maryland law requires health carriers to include specific benefits in their health benefit plan contracts. These are called "mandated benefits" because the law mandates insurance carriers provide them. Maryland law also requires that certain other benefits be made available upon request. These are called "mandatory offerings." The requirements of the law depend on what type of plan you have. The law does not require an HMO to provide all of the mandatory benefits that are required from an insurance company. Your contract may have exclusions that are not described here or may include many benefits that are not required by law.

This section describes the mandatory benefits that are contained in your contract.

Who is protected by Maryland's mandated benefits?

Even though you are a resident of Maryland, you may have a health benefit plan that does not cover all of these benefits. There are several reasons why this might happen:

- You work for a small employer. Small employers have fewer than 50 eligible employees and are covered by the Comprehensive Standard Health Benefit Plan. This Plan has benefits determined by the Maryland Health Care Commission. The details of those benefits are found in A Guide to Purchasing Health Insurance for Small Employers, which can be found at www.mhcc.state.md.us or by contacting the Maryland Health Care Commission at:

4160 Patterson Avenue
Baltimore, Maryland 21215
(410) 764-3460
(877) 245-1762

You may also obtain this information by contacting us at:

525 Saint Paul Place
Baltimore, Maryland 21202
(410) 468-2000
(800) 492-6116

- You are covered under the Maryland Health Insurance Plan (MHIP). This is a State high risk pool for individuals with certain health conditions, those who are HIPAA eligible, and those who cannot obtain an individual policy due to health reasons as well as other circumstances. Under State law, MHIP is exempt from mandated benefits, and its benefits are set by its board of directors. MHIP covers many mandated benefits, and offers comprehensive health coverage, but does not cover all mandated benefits.
- You are covered under a group policy issued to the group's home office in another state. If you work for an employer based in another state, your health insurance policy may have been issued in that state. Maryland does not regulate policies issued in other states. This also applies if you are an individual insured by a group policy issued to an association in another state.
- You work for the federal government. States do not regulate federal government health programs.

- Your employer self-funds its health benefit plan. Many large employers do not purchase insurance for their employees' health benefit plan. Instead, they hire an insurance company to perform administrative services, such as processing claims for payment. The employer is still responsible for providing the money to pay the claims. There is no health insurance policy issued, so laws governing what must be covered in health insurance policies do not apply. Check with your employer to find out whether you are in a self-insured plan.
- You are covered under Medicare or Medicaid. These are federal programs that are not subject to state insurance law relating to benefits.

This section does not apply to Medicare Supplement contracts. For additional information, see the *Guide to Health Insurance for People with Medicare* developed jointly by the federal Centers for Medicare and Medicaid Services (CMS) and the National Association of Insurance Commissioners (NAIC).

The Mandated Benefit Chart

The chart contains a list of mandated benefits and identifies which plans must provide these benefits.

Mandatory Offerings

The following coverages must be offered in certain situations:

Alzheimer's Disease Treatment – This optional benefit covers treatment for Alzheimer's Disease. Only group insurers and nonprofit group plans must offer this coverage as referenced in §15-801 of the Insurance Article.

Disability Benefits for Disabilities Caused by Pregnancy or Childbirth – Insurers offering group policies that provide benefits for temporary disability shall offer the policyholder the option of providing benefits for temporary disability caused or contributed by pregnancy or childbirth as referenced in §15-813 of the Insurance Article.

Hospice Services – Inpatient and Outpatient – This optional benefit covers the services of hospice, a coordinated care program for people who are dying and their family members. This offering must be made by group and individual insurers and also by nonprofit health service plans as referenced in §15-809 of the Insurance Article. It is also applicable to HMOs pursuant to §19-703(c) of the Health – General Article.

What you can do if your health plan has not provided these benefits

First, you should determine whether the benefit is covered by your health plan. You can look at your contract or call the customer service line to get that question answered. If the service is covered by your plan but the health plan is denying your coverage, you should file an appeal with the health plan. You should send a written appeal; a telephone call may not be enough. If your request for pre-authorization of services was denied, you have not yet received the services, and it is an emergency, you may request an expedited appeal. You may also receive an expedited appeal if your company says it is going to stop paying for services. You may also contact the Maryland Insurance Administration at (800) 492-6116 and we may be able to assist you. You should carefully review your certificate of coverage or policy and the denial notice that was sent to you to learn how to file an appeal. You should file your appeal as soon as possible. Your appeal may be denied by the health plan if it is past their deadline for appeals. The Health Education and Advocacy Unit in the Office of the Attorney General may assist you in preparing your appeal. Their toll-free telephone number is (877) 261-8807, and their web site is www.oag.state.md.us. (Complaint forms are available online.) If you are covered by a health insurance or HMO policy issued in Maryland, you only need to file one appeal with the company.

After you have received an appeal decision, if you remain dissatisfied, and your coverage is subject to Maryland law, you may file a complaint with the Maryland Insurance Administration. In some cases, you may be able to file a complaint regarding a denial based on medical necessity if you reside in Maryland, even if your policy was issued in another state. You may also file a complaint with the Insurance Administration if a claim is denied because your company states that the service is not covered by your policy. Our web site, www.mdinsurance.state.md.us has both complaint forms and authorizations to release medical records that you may print out and send to us. You should include copies of the denial letters you received from the company and any other correspondence you have. For further assistance, our toll-free number is (800) 492-6116.

Mandated Benefits

This chart includes a list and a brief description of all of the benefits mandated under Maryland law. As indicated in the introduction to this brochure, the requirements of the law depend on what type of plan you have. Therefore, you will need to look at your particular plan to see if your plan includes the mandate. The citation for the statute that provides the benefit is listed. If the box is blank, that indicates that the benefit is not mandated by law for your particular plan.

MANDATE	DESCRIPTION OF BENEFIT	INSURER	HMO	NONPROFIT HEALTH SERVICE PLAN
Anesthesia for Dental Care	Limited coverage for minors for anesthesia and associated hospital or ambulatory charges in conjunction with dental care.	Insurance Article §15-828	Health – General Article §19-706(i)	Insurance Article §15-828
Blood Products	Payment for blood products may not be excluded.	Insurance Article §15-803	Health – General Article §19-706(r)	Insurance Article §15-803
Breast Prosthesis	Requires carriers to provide coverage for a prosthesis prescribed by a physician where the member has had a mastectomy but has not had reconstructive surgery.	Insurance Article §15-834	Health – General Article §19-706(ii)	Insurance Article §15-834
Child Wellness	Covers certain preventative services including immunizations and screening tests for disease and problems.	Insurance Article §15-817	Health – General Article §19-705.1(d)(4) and (5)	Insurance Article §15-817
Chlamydia Screening	Covers screening for sexually active women under the age of 20 and for men and women who have multiple risk factors.	Insurance Article §15-829	Health – General Article §19-706(ff)	Insurance Article §15-829
Cleft Lip/Cleft Palate	Includes coverage for orthodontics, oral surgery, otologic, audiological and speech and language treatments.	Insurance Article §15-818	Health – General Article §19-706(bb)	Insurance Article §15-818
Clinical Trials	Provides for coverage of approved clinical trials for treatment provided for a life-threatening condition or prevention, early detection and treatment studies on cancer.	Insurance Article §15-827	Health – General Article §19-706(aa)	Insurance Article §15-827
Colorectal Cancer Screening	Covers colorectal screening in accordance with the latest screening guidelines issued by the American Cancer Society.	Insurance Article §15-837	Health – General Article §19-706(rr)	Insurance Article §15-837

MANDATE	DESCRIPTION OF BENEFIT	INSURER	HMO	NONPROFIT HEALTH SERVICE PLAN
Contraceptive Drugs or Devices	This mandate only applies to individuals that have prescription coverage. It applies to FDA approved drugs or devices that are prescribed for use as a contraceptive. Also covers insertion or removal of contraceptive devices as well as any medically necessary examination associated with the use of a contraceptive drug or device. [Subject to the requirements of §15-826, health coverage provided through a religious organization may exclude this mandated health benefit.]	Insurance Article §15-826	Health – General Article §19-706(i)	Insurance Article §15-826
Diabetic Equipment and Supplies	Covers all medically appropriate and necessary diabetes equipment, diabetic supplies, and diabetes outpatient self-management training and educational services, including medical nutrition therapy. Covers insulin pumps, but does not cover insulin.	Insurance Article §15-822	Health – General Article §19-706(x)	Insurance Article §15-822
Emergency Room Services	This benefit covers the cost of emergency room visits.		Health – General Article §19-701(g)(2)	
Extension of Benefits	Requires carriers to extend certain benefits under specific circumstances except when coverage is terminated because of specified conditions. Charging of premiums is prohibited when benefits are extended.	Insurance Article §15-833	Health – General Article §19-706(hh)	Insurance Article §15-833
Gynecological Care	In the instances where the patient belongs to a health plan that requires the member to receive a referral prior to receiving treatment from a specialist, the law provides that women must have direct access to gynecological care from an in-network obstetrician/gynecologist or other non-physician, including a certified nurse midwife, who is not her primary care physician; requires an obstetrician/gynecologist to confer with a primary care physician.	Insurance Article §15-816	Health – General Article §19-706(i)	Insurance Article §15-816
Habilitative Services	Covers services, including occupational therapy, physical therapy, and speech therapy, for the treatment of a child with a congenital or genetic birth defect to enhance the child's ability to function. Coverage is not required for services delivered through early intervention or school services.	Insurance Article §15-835	Health – General Article §19-706(nm)	Insurance Article §15-835

MANDATE	DESCRIPTION OF BENEFIT	INSURER	HMO	NONPROFIT HEALTH SERVICE PLAN
Hair Prosthesis (Wigs)	Covers a hair prosthesis prescribed by the oncologist in attendance where the hair loss results from chemotherapy or radiation treatment for cancer. The coverage is for one prosthesis and the benefit may be limited to \$350.	Insurance Article §15-836	Health – General Article §19-706(i)	Insurance Article §15-836
Hearing Aids for Minor Children	Covers hearing aids that are prescribed, fitted and dispensed by a licensed audiologist. The benefit may be limited to \$1,400 per hearing aid for each impaired ear every 36 months.	Insurance Article §15-838	Health – General Article §19-706(tt)	Insurance Article §15-838
Home Health Service	Health insurance policies that provide coverage for inpatient hospital care on an expense-incurred basis must provide coverage for home health care. The carrier may limit visits to 40 visits in any calendar year.	Insurance Article §15-808		Insurance Article §15-808
Human Papillomavirus Screening Test	New plans shall provide coverage for a FDA approved Human Papillomavirus screening at the testing intervals outlined in the recommendations for cervical cytology screening developed by the American College of Obstetricians and Gynecologists for women who are under the age of 20 years if they are sexually active; and at least 20 years old if they have multiple risk factors; and men who have multiple risk factors. This is applicable to policies that are issued, delivered, or renewed in Maryland on or after October 1, 2005.	Insurance Article §15-829	Health – General Article §19-706(ff)	Insurance Article §15-829
Infertility Benefits	<i>In Vitro Fertilization</i> – Carriers that provide pregnancy-related benefits may not exclude benefits for all outpatient expenses arising from IVF procedures. The benefits shall be provided the same as for other pregnancy-related procedures. The patient or the patient's spouse must have a history of infertility of at least 2 years or have become infertile from endometriosis, exposure to DES, blockage or removal of fallopian tubes, or abnormal male factors. Carriers may limit the benefit to \$100,000 per lifetime and three attempts per live birth.	Insurance Article §15-810	Health – General Article §19-706(oo)	Insurance Article §15-810
Inpatient Hospital Services	This benefit covers the cost of a hospital stay.		Health – General Article §19-701(g)(2)	

MANDATE	DESCRIPTION OF BENEFIT	INSURER	HMO	NONPROFIT HEALTH SERVICE PLAN
Laboratory Services	This benefit covers tests, ordered by a doctor or other health care provider, that are conducted at a lab.		Health – General Article §19-701(g)(2)	
Mammograms		Insurance Article §15-814 [includes coverage for a baseline mammogram for women who are 35 to 39, a biannual mammogram for women who are 40 to 49, and an annual mammogram for women who are at least 50]	Covered as a preventative service pursuant to Health – General §19-701 (g)(2)	Insurance Article §15-814 [includes coverage for a baseline mammogram for women who are 35 to 39, a biannual mammogram for women who are 40 to 49, and an annual mammogram for women who are at least 50]
Mastectomies/ Surgical Removal of Testicles	Requires carriers to cover at least 1 home health visit within 24 hours after discharge for a patient who had less than 48 hours of inpatient hospitalization after a mastectomy or surgical removal of a testicle, or who undergoes either procedure on an outpatient basis. Additionally, visits will be covered if ordered by the physician.	Insurance Article §15-832	Health – General Article §19-706(gg)	Insurance Article §15-832
Medical Foods	Covers medical foods and low protein modified food products for the treatment of inherited metabolic diseases if the medical foods or low protein modified food products are: (1) prescribed as medically necessary for therapeutic treatment of inherited metabolic diseases; and, (2) administered under the direction of a physician.	Insurance Article §15-807	Health – General Article §19-705.5	Insurance Article §15-807

MANDATE	DESCRIPTION OF BENEFIT	INSURER	HMO	NONPROFIT HEALTH SERVICE PLAN
<p>Mental Health/ Substance Abuse Treatment</p> <p>{Mental Health Parity – All policies providing coverage For health care may not discriminate against any person with a mental illness, emotional disorder, or drug abuse or alcohol abuse disorder by failing to provide benefits for treatment and diagnosis of these illnesses under the same terms and conditions that apply under the contract or policy for treatment of physical illness}</p>	Inpatient Services – covered the same as inpatient services for physical illness.	Insurance Article §15-802	Health – General Article §19-703.1	
	Partial Hospitalization – a minimum of at least 60 days of partial hospitalization.	Insurance Article §15-802	Health – General Article §19-703.1	
	Outpatient Services – 80% coverage for first 5 visits in any calendar year or benefit period; 65% coverage for 6-30 visits; 50% coverage for 31 st visit and any visits after the 31 st . For all contracts that are issued, delivered or renewed in Maryland on or after October 1, 2005, this shall include psychological and neuropsychological testing for diagnostic purposes.	Insurance Article §15-802	Health – General Article §19-703.1	
	Medication Management – visits are covered the same as medication management for physical illness.	Insurance Article §15-802	Health – General Article §19-703.1	
	New Methadone Maintenance Treatment – a copayment that is greater than 50% of the daily cost for methadone maintenance treatment may not be charged.	Insurance Article §15-802	Health – General Article §19-703.1	
	Residential Crisis Services – Coverage for medically necessary residential crisis services defined as intensive mental health and support services: (1) provided to a child or an adult with a mental illness at risk of a psychiatric crisis; (2) designed to prevent or provide an alternative to a psychiatric inpatient admission, or shorten the length of inpatient stay; (3) provided at the residence on a short-term basis; and (4) provided by DHMH-licensed entities.	Insurance Article §15-840	Health – General Article §19-706(yy)	Insurance Article §15-840

MANDATE	DESCRIPTION OF BENEFIT	INSURER	HMO	NONPROFIT HEALTH SERVICE PLAN
Morbid Obesity	Coverage for the surgical treatment of morbid obesity that is: (1) recognized by the National Institutes of Health as effective for the long-term reversal of morbid obesity; and (2) consistent with guidelines approved by the National Institutes of Health.	Insurance Article §15-839	Health – General Article §19-706(uu)	Insurance Article §15-839
Osteoporosis Prevention and Treatment	Coverage for qualified individuals for reimbursement for bone mass measurement for the prevention, diagnosis, and treatment of osteoporosis when the bone mass measurement is requested by a health care provider for the qualified individual.	Insurance Article §15-823	Health – General Article §19-706(p)	Insurance Article §15-823
Physician Services	This benefit covers the services of a physician.		Health – General Article §19-701(g)(2)	
Pregnancy and Maternity Benefits	<i>Child Birth Benefits</i> – Every insurance policy that provides hospitalization benefits for normal pregnancy must provide hospitalization benefits to the same extent as that for any covered illness. In addition, whenever a mother is required to remain hospitalized after childbirth for medical reasons and the mother requests that the newborn remain in the hospital, the insurer or nonprofit health service plan shall pay the cost of additional hospitalization for the newborn for up to 4 days. <i>Inpatient Hospital Coverage for Mothers and Newborns</i> – Requires carriers to provide inpatient hospitalization coverage for a mother and newborn child for a minimum of 48 hours after an uncomplicated vaginal delivery and 96 hours after an uncomplicated caesarean section; authorizes a home visit by an experienced registered nurse if the mother requests a shorter hospital stay and an additional home visit if prescribed by the provider; and prohibits sanctions against a provider who advocates a longer stay.	Insurance Article §15-811	Health – General Article §19-703(g)	Insurance Article §15-811
		Insurance Article §15-812	Health – General Article §19-706(i)	Insurance Article §15-812

MANDATE	DESCRIPTION OF BENEFIT	INSURER	HMO	NONPROFIT HEALTH SERVICE PLAN
<p>Prescription Benefits</p> <p>{Note: Carriers are not required to provide prescription drug benefits. When benefits are provided, these laws apply.}</p>	<p><i>Off-Label Use of Drugs</i> – A policy or contract that provides coverage for drugs may not exclude coverage for a drug for an off-label use of the drug if the drug is recognized for treatment in any of the standard reference compendia or in the medical literature. Coverage of a drug required by this subsection also includes medically necessary services associated with the administration of the drug.</p>	<p>Insurance Article §15-804</p>	<p>Health – General Article §19-706(i)</p>	
	<p><i>Reimbursement for Pharmaceutical Products</i> – subject policies cannot establish varied reimbursement based on the type of prescriber and cannot vary copayments, deductibles, or any other condition based on community pharmacy vs. mail order.</p>	<p>Insurance Article §15-805</p>		<p>Insurance Article §15-805</p>
	<p><i>Choice of Pharmacy</i></p>			<p>Insurance Article §15-806 [the nonprofit health service plan shall allow the member to fill prescriptions at the pharmacy of choice]</p>
	<p><i>Maintenance Drug Coverage</i> – Carrier shall allow the insured to receive up to a 90-day supply of a prescribed maintenance drug in a single dispensing, except for new prescriptions or changes in prescriptions. If carrier increases copayment, they shall proportionally increase the dispensing fee.</p>	<p>Insurance Article §15-824</p>	<p>Health – General Article §19-706(q)</p>	<p>Insurance Article §15-824</p>
	<p><i>Use of Formulary</i> – Each entity limiting its coverage of Rx drugs or devices to those in a formulary shall establish & implement a procedure for a member to receive a Rx drug or device that is not in the entity's formulary when there is no equivalent Rx drug or device in the entity's formulary, or an equivalent Rx drug is ineffective or has caused an adverse reaction.</p>	<p>Insurance Article §15-831</p>	<p>Health – General Article §19-706(gg)</p>	<p>Insurance Article §15-831</p>

MANDATE	DESCRIPTION OF BENEFIT	INSURER	HMO	NONPROFIT HEALTH SERVICE PLAN
Preventative Services	This benefit covers all preventative services that are meant to help prevent disease and injury.		Health – General Article §19-701(g)(2)	
Prosthetic Devices	Coverage for prosthetic and orthopedic devices.			Insurance Article §15-820
Prostate Cancer Screening	Coverage shall be provided for a medically recognized diagnostic examination including a digital rectal exam and prostate-specific antigen (PSA) test for: 1) men between 40 and 75; 2) when used for the purpose of guiding patient management in monitoring the response to prostate cancer treatment; 3) when used for staging in determining the need for a bone scan in patients with prostate cancer; or 4) when used for male patients who are at high risk for prostate cancer.	Insurance Article §15-825	Health – General Article §19-706(u)	Insurance Article §15-825
Reconstructive Breast Surgery	Requires carriers to provide coverage for reconstructive breast surgery resulting from a mastectomy to reestablish symmetry between the two breasts. Treatment may include surgery on the nondiseased breast to establish symmetry.	Insurance Article §15-815	Health – General Article §19-706(d)(2)	Insurance Article §15-815
Referrals to Specialist	Requires carriers that do not allow direct access to specialists to establish and implement a procedure by which a member may receive, under certain circumstances, a standing referral to a participating specialist and under certain circumstances to a non-participating specialist; provides pregnant members with a standing referral to an obstetrician.	Insurance Article §15-830	Health – General Article §19-706(gg)	Insurance Article §15-830
Second Opinions and Coverage of Outpatient Services	If a hospital's utilization review program denies inpatient confinement, the carrier is required to cover an objective second opinion. If a utilization review program denies an inpatient admission, the carrier is required to cover a corresponding outpatient service that is provided to the individual instead of the inpatient service.	Insurance Article §15-819		Insurance Article §15-819

MANDATE	DESCRIPTION OF BENEFIT	INSURER	HMO	NONPROFIT HEALTH SERVICE PLAN
Smoking Cessation	<p>Plans that provide prescription coverage must provide coverage for any drug that is not an over-the-counter product that is approved by the FDA as an aid for the cessation of the use of tobacco products; and is obtained under a prescription written by an authorized prescriber. The plan also shall provide two 90-day courses of nicotine replacement therapy during each policy year.</p> <p>Copayments or coinsurance amounts for drugs provided must be the same as that for comparable prescriptions.</p> <p>This mandate is effective for policies issued, delivered or renewed in Maryland on or after October 1, 2005.</p>	Insurance Article §15-841	Health – General Article §19-706(ddd)	Insurance Article §15-841
Temporo-Mandibular Joint Syndrome (TMJ) Treatment	Health insurers that provide coverage for a diagnostic or surgical procedure involving a bone or joint of the skeletal structure may not exclude or deny coverage for the same diagnostic or surgical procedure involving a bone or joint of the face, neck, or head if the procedure is medically necessary to treat a condition caused by a congenital deformity, disease, or injury.	Insurance Article §15-821		Insurance Article §15-821
X-Ray	This benefit covers x-rays ordered by a doctor or other health professional.		Health – General Article §19-701(g)(2)	

Frequently Asked Questions:

Why Doesn't My Health Plan Cover All Mandated Benefits?

Maryland law requires health carriers to include certain specific benefits in their health benefit plan contracts issued in Maryland. Even though you are a resident of Maryland, you may have a health benefit plan that does not cover all of these benefits. There are several reasons why this might happen:

- You work for a small employer. Small employers have fewer than 50 eligible employees and are covered by the Comprehensive Standard Health Benefit Plan. This Plan has benefits determined by the Maryland Health Care Commission. The Plan includes many mandated benefits, as well as benefits that are not mandated, but is not required to include all mandated benefits.
- You are covered under the Maryland Health Insurance Plan. This is a State high risk pool for individuals with certain health conditions, those who are HIPAA eligible, and those who cannot obtain an individual policy due to health reasons as well as other circumstances. Under State law, MHIP is exempt from mandated benefits, and its benefits are set by its board of directors. MHIP covers many mandated benefits, and offers comprehensive health coverage, but does not cover all mandated benefits.
- You are covered under a group policy issued to the group's home office in another state. If you work for an employer based in another state, your health insurance policy may have been issued in that state. Maryland does not regulate policies issued in other states. This also applies if you are an individual insured by a group policy issued to an association in another state.
- You work for the federal government. States do not regulate federal government health programs.
- Your employer self-funds its health benefit plan. Many large employers do not purchase insurance for their employees' health benefit plan. Instead, they hire an insurance company to perform administrative services, such as processing claims for payment. The employer is still responsible for providing the money to pay the claims. There is no health insurance policy issued, so laws governing what must be covered in health insurance policies do not apply.
- You are covered under Medicare or Medicaid. These are federal programs that are not subject to state insurance law relating to benefits.

If you have questions, you may call us at (800) 492-6116.

COBRA AND CONTINUATION OF COVERAGE UNDER MARYLAND LAW



COBRA AND CONTINUATION OF COVERAGE UNDER MARYLAND LAW

In 2002, the MIA issued Bulletin 02-20, which sets forth Maryland law on continuation of coverage. The full text of that bulletin is as follows:

BULLETIN

Re: MARYLAND CONTINUATION COVERAGE
Maintaining group health insurance benefits after leaving the group

Date: October 1, 2002

Bulletin: Life and Health 02-20

*This Bulletin replaces Life and Health Bulletin 00-15, regarding Maryland Continuation Coverage. The only change from the prior Bulletin is found in the **Termination of Employment** section of this Bulletin.*

Most people are familiar with the federal Consolidated Omnibus Budget Reconciliation Act (COBRA), which requires issuers of health insurance coverage to continue to offer to individuals who leave an employer group the same terms of coverage that it issues to the group. Maryland also has laws requiring insurers, nonprofit health service plans, and health maintenance organizations (HMO's) to offer continuation coverage to individuals who lose group membership through three events: involuntary termination of employment, death, or divorce.

While Maryland's continuation laws and COBRA have many similarities, there are some important differences. A comparison chart is attached to this bulletin. When either state or federal law could be applied, an individual need not make an election of one or the other. Rather, the Administration has taken the position that Maryland consumers who qualify for either state or federal law are entitled to choose both, and if there are differences in qualifications or benefits, those differences are to be resolved in favor of the consumer. There are some situations for which continuation coverage may only be available under COBRA, and other situations for which continuation may only be available under Maryland law. For example, only Maryland's law requires continuation coverage for an individual whose employer group has fewer than 20 employees.

An individual must meet the requirements to qualify for continuation coverage. Different requirements apply to each event that results in loss of group membership. Under all continuation laws, the person continuing coverage must pay the full amount of the premium, including the portion formerly paid by the employer. There may also be an administrative fee added to the premium.

Continuation coverage is always made available without evidence of insurability. Usually a form is filed with the employer indicating that the person is eligible to, and wants to, continue coverage. The effective date of coverage is the date of the event that causes loss of group membership. The benefits provided are the same as those provided to other members of the group. Coverage terminates after a fixed period of time or on the occurrence of a subsequent event. Failure to make timely payments for coverage also would result in its termination.

An individual who does not qualify for continuation coverage may be able to obtain a conversion policy. However, a conversion policy will typically have higher premiums and fewer benefits than continuation coverage. Alternatively, the individual may be eligible for individual coverage, issued without medical underwriting and with no preexisting condition limitations, under the Health Insurance Portability and Accountability Act (HIPAA).

Individuals who have health insurance through group membership and who may lose group membership through termination of employment, death, or divorce, should read the provisions governing continuation that are part of the contract between the group policyholder (the employer) and the issuer of the health insurance coverage, as well as Maryland law and regulations, in their entirety. Text of the law is available at www.mlis.state.md.us. Text of the regulations is available through the home page of the Maryland Secretary of State, Division of State Documents at www.dsd.state.md.us.

Following is a summary of important provisions related to each event that results in loss of group membership.

Termination of Employment

§15-409 of the Insurance Article
COMAR 31.11.04

Maryland law requires continuation coverage be offered to an employee who voluntarily terminates employment or whose employment is involuntarily terminated other than for cause. To qualify for continuation coverage under Maryland law, an individual must be a resident of Maryland who had health insurance coverage under a group contract with the same employer for at least three months before the termination.

The individual must submit a signed election for continuation coverage within the 45-day period following the date of termination of employment. An administrative fee of up to 2% of the total premium may be added to the cost of coverage. The individual pays the premium each month to the employer.

Continuation coverage ends after 18 months, or earlier for any of the following reasons:

- For not making payments on time
- If the individual becomes eligible for coverage under another group expense-incurred medical insurance policy or HMO
- If the individual becomes entitled to benefits under Medicare
- If the individual becomes covered under a non-group expense-incurred medical insurance policy or HMO
- If the individual terminates the coverage
- If the employer no longer offers any group health benefit plan.

Death of a Covered Employee

§15-407 of the Insurance Article
COMAR 31.11.03

Maryland law requires continuation coverage be offered to the surviving spouse and dependent children (qualified secondary beneficiary) of an employee who dies. The employee must have been a resident of Maryland who had health insurance coverage under a group contract with the same employer for at least three months before death. Additionally, coverage must be offered to a child of the employee who is born to the surviving spouse after the employee's death.

The qualified secondary beneficiary or authorized representative must submit a signed election for continuation coverage within the 45-day period following the date of the employee's death. An administrative fee of up to 2% of the total premium may be added to the cost of coverage. The qualified secondary beneficiary pays the premium each month to the employer.

For a dependent child of the deceased employee, continuation coverage ends on the date on which the child would no longer be covered under the group contract if the employee had not died.

For a surviving spouse, continuation coverage ends after 18 months.

For an individual who is either a dependent child or surviving spouse, continuation coverage ends earlier than described above for any of the following reasons:

- For not making payments on time
- If the individual becomes eligible for coverage under another group expense-incurred medical insurance policy or HMO
- If the individual becomes entitled to benefits under Medicare
- If the individual becomes covered under a non-group expense-incurred medical insurance policy or HMO
- If the individual terminates the coverage
- If the employer no longer offers any group health benefit plan.

Divorce

§15-408 of the Insurance Article
COMAR 31.11.02

Maryland law requires continuation coverage be offered to the former spouse and dependent children (qualified secondary beneficiary) of an employee after a divorce. Additionally, coverage must be offered to a child of the employee who is born to the former spouse after the divorce. Divorced spouses and dependent children are entitled to continuation coverage only while the employee is covered by a group contract.

Notice of the divorce must be given to the employer. If the employee later obtains group coverage through a different employer, a notice must be given to that employer in order to maintain continuation coverage. The costs of the continuation coverage are paid by the employee, who may be reimbursed for all or part of the extra expense by the former spouse, by agreement of the parties or by court order.

For a dependent child of the employee, continuation coverage ends on the date on which the child would no longer be covered under the group contract if the divorce had not occurred. Otherwise, coverage may be terminated for any of the following reasons:

- For the former spouse, on remarriage
- For not making payments on time
- For a qualified secondary beneficiary, on becoming eligible for coverage under another group expense-incurred medical insurance policy or HMO
- For a qualified secondary beneficiary, on becoming entitled to benefits under Medicare
- For a qualified secondary beneficiary, on becoming covered under a non-group expense-incurred medical insurance policy or HMO
- On termination of the coverage by the qualified beneficiary
- If the employer no longer offers any group health benefit plan.

Additional information on how to obtain continuation coverage may be found in the Certificate of Coverage issued by the insurance company or HMO.

Six-Month Continuation

(Not applicable to HMOs or to small group contracts)
COMAR 31.11.10.14

A regulation adopted by the Maryland Insurance Administration before federal COBRA was enacted still exists to provide continuation coverage of a very limited scope. The regulation requires continuation coverage for a six-month period to be offered to an individual who has been covered for at least 3 months under a group policy, and who loses that coverage for any reason except the following: the individual became eligible for Medicare, reached a limiting age specified in the policy, or failed to pay a required premium or contribution.

Health maintenance organizations are not subject to the regulation. Also, another regulation, which establishes the benefits for the Comprehensive Standard Health Benefit Plan for small employer groups in Maryland (up to 50 eligible employees), excludes 6-month continuation coverage for all small employer groups, even if the group coverage is issued by a nonprofit health service plan or an insurer. Therefore, an individual may not obtain six-month continuation coverage if the individual's group coverage is regulated under the small employer group market, or is issued by a health maintenance organization.

An individual who obtains the six-month continuation coverage must pay the monthly premiums to the employer. If the employer terminates the group policy or refuses to send the premiums to the insurance company due to a labor dispute, the individual may pay the insurer directly. In that case, the insurer may charge an administrative fee of up to 20% of the premium.

Howard Max
Acting Associate Commissioner
Life and Health
Continuation of Benefits

Continuation of Benefits

Comparison of Maryland and Federal Provisions

Qualifying Events (QE)	Termination of Employment		Death of Covered Employee		Divorce		Cessation of Dependency for Child
	IN §15-409 COMAR 31.11.04	COBRA*	IN §15-407 COMAR 31.11.03	COBRA*	IN §15-408 COMAR 31.11.02	COBRA*	
Applicable Cites							
Qualification - coverage requirement prior to QE <ul style="list-style-type: none"> insured employee 	3 months with same employer (applies if employee is terminated for other than cause)	covered day before QE (applies if employee is terminated for other than gross misconduct or coverage is lost due to reduction in work hours)	3 months with same employer	covered day before QE	no minimum	covered day before QE	covered day before QE
<ul style="list-style-type: none"> spouse 	No minimum	covered day before QE; has independent right to elect continuation	30 days as spouse of insured employee	covered day before QE; has independent right to elect continuation	30 days as spouse of insured employee	covered day before QE; has independent right to elect continuation	covered day before QE; has independent right to elect continuation
<ul style="list-style-type: none"> dependent child 	covered immediately before QE	covered day before QE; has independent right to elect continuation	child of employee covered immediately before QE or born after QE includes spouse and dependent child	covered day before QE; has independent right to elect continuation not applicable	child of employee covered immediately before QE or born after QE includes ex-spouse and dependent child	covered day before QE; has independent right to elect continuation not applicable	covered day before QE; has independent right to elect continuation not applicable
Qualified Secondary Beneficiary (QSB) Definition	not applicable	not applicable	includes spouse and dependent child	not applicable	includes ex-spouse and dependent child	not applicable	not applicable
Length of Continuation	18 months	18 months (29 months for SSA disabled--)	18 months	3 years	terminates only for causes listed below	3 years	3 years

Qualifying Events (QE)	Termination of Employment		Death of Covered Employee		Divorce		Cessation of Dependency for Child
	IN §15-409 COMAR 31.11.04	COBRA*	IN §15-407 COMAR 31.11.03	COBRA*	IN §15-408 COMAR 31.11.02	COBRA*	
Applicable Cites							COBRA*
		must certify prior to expiration of 18 month extension)					
Employer responsibility - notification/furnishing forms	14 days after request for election is received	30 days notification	14 days after request for election is received	30 days notification	not applicable	30 days notification	30 days notification
Employee responsibility - time for notification/election	up to 45 days after QE; notice signed by insured employee	60 days from <u>later of</u> receipt of notification or date of QE	up to 45 days after QE; notice signed by QSB	60 days from <u>later of</u> receipt of notification or date of QE	up to 60 days after divorce; notice signed by insured employee	60 days from <u>later of</u> receipt of notification or date of QE	60 days from <u>later of</u> receipt of notification or date of QE
Payment of premiums - a) amount and mode of payment	102%; monthly	102% 150% for 11 month disability extension	102%; monthly	102%	100%	102%	102%
b) requirements for payment of first premium	covers date of QE to last day of month of election	due up to 45 days after election	covers date of QE to last day of month of election	due up to 45 days after election	due on the date notice is given	due up to 45 days after election	due up to 45 days after election
Permissible Reasons to Terminate Coverage							
a) non-payment of premium	Yes	Yes	Yes	Yes	Yes	Yes	Yes
b) becomes entitled to benefits under Medicare	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Permissible Reasons to Terminate Coverage (continued)							

Qualifying Events (QE)	Termination of Employment		Death of Covered Employee		Divorce		Cessation of Dependency for Child
	IN §15-409 COMAR 31.11.04	COBRA*	IN §15-407 COMAR 31.11.03	COBRA*	IN §15-408 COMAR 31.11.02	COBRA*	
c) becomes eligible for other group coverage	Yes	Permitted only if person is actually covered and no pre-existing condition applies under new group coverage	Yes	Permitted only if person is actually covered and no pre-existing condition applies under new group coverage	Yes	Permitted only if person is actually covered and no pre-existing condition applies under new group coverage	Permitted only if person is actually covered and no pre-existing condition applies under new group coverage
d) becomes covered under a similar non-group contract	Yes	No	Yes	No	Yes	No	No
e) covered person cancels coverage	Yes	Yes	Yes	Yes	Yes	Yes	Yes
f) employer no longer offers group coverage	Yes	Yes	Yes	Yes	Yes (may also terminate coverage of divorced spouse if employee is no longer covered under group plan)	Yes	Yes
g) dependent child no longer qualifies	Yes	No	Yes	No	Yes	No	No
h) QSB ex-spouse remarries	No	No	No	No	Yes	No	not applicable

Frequently Asked Questions:

My COBRA Coverage Is Ending. What Can I Do?

If you have been continuing coverage under a group plan, and your continuation coverage is ending, you have several options to consider:

Option 1:

If you or your spouse has group coverage available at work, you may be eligible for a special enrollment period in that group policy. This means that you can enroll even if you did not during open enrollment. You should enroll as soon as possible. You may be unable to enroll if you wait too long after your continuation coverage ends. Your new employer, or your spouse's employer, should be able to tell you if you qualify.

Option 2:

If you are in very good health, you may consider applying for an individual, medically underwritten health policy. "Medically underwritten" means that the insurance company or health maintenance organization (HMO) may deny your application if you do not meet their standards of good health. It is important to answer all of the questions on the application honestly and thoroughly. Your policy may be cancelled later if your application had errors. A medically underwritten policy will be less expensive than an individual policy that does not require evidence of good health. A list of companies selling individual policies is available on our web site, www.mdinsurance.state.md.us.

Option 3:

You may be able to convert your current group coverage to an individual policy with the same company. Conversion policies do not require you to prove you are in good health. The benefits may not be the same as with your group policy, and the premiums may be higher.

Option 4:

You may have heard references to the federal law called HIPAA. You will receive a certificate of creditable coverage from your current insurance company when your coverage ends. This creditable coverage will offset any waiting period for coverage of a pre-existing condition under a new policy. HIPAA also gives you the right to coverage at the end of continuation coverage. In Maryland, you can obtain this coverage through the Maryland Health Insurance Plan (MHIP). MHIP is a State-administered plan for people with certain medical conditions, HIPAA eligible individuals, and people who are denied a medically underwritten policy, as well as certain other categories. There are several delivery options, all of which require a premium payment. Their web site is www.marylandhealthinsuranceplan.state.md.us. Their telephone number is (866) 780-7105.

I'm Leaving My Job. How Do I Keep My Health Insurance?

Option 1:

If you are married, and your spouse has health coverage available at work, you and your family may be able to enroll in your spouse's plan. You must enroll within 30 days of termination of your employment. You may be able to do this even if it is not open enrollment. Check with your spouse's Human Resources department for the specific rules.

Option 2:

You may be able to continue your coverage under COBRA, which is a federal law. COBRA only applies to employers with 20 or more employees. Information about COBRA is available at www.dol.gov.

Option 3:

You may be able to continue your group coverage under Maryland Continuation Coverage laws. These laws apply to groups of any size, if the group policy is a Maryland contract and is not self-funded. Check with your Human Resources department to find out if your policy was issued and delivered in another state or is self-funded.

Under Maryland law, you are eligible for continuation coverage if:

- You quit your job voluntarily, or you are involuntarily terminated, but not for cause.
- You were covered under the group health plan for at least 3 months before termination.
- You are a resident of Maryland.

You must notify your employer as soon as possible if you want to continue coverage. Your employer is required by law to supply you with an election notification form within 14 days of your request. You must complete, sign, and return this form to your employer within 45 days of your termination. Detailed information about Maryland Continuation Coverage law is available in Section D of this brochure.

Option 4:

You may also be able to obtain an individual conversion policy without regard to your health status. This policy may not include all of the benefits you had under your group policy, and may be more expensive than group coverage.

You should carefully read your certificate of coverage to learn more about continuation options. There are some important differences between Maryland law and COBRA.

I Just Got Divorced. May I Stay On My Ex-Spouse's Insurance Policy?

If you were covered as a spouse under an employer group health benefit plan, you may be able to remain in the employer's group health plan. Most people have heard of the federal law called COBRA, which allows people who get divorced to continue their health insurance coverage under their ex-spouse's employer group plan. COBRA only applies to employers with 20 or more employees. Maryland also has laws that require continuation of group coverage. These laws apply to groups of any size, provided that the group policy is issued in Maryland and is not self-funded by the employer. Your Human Resources department can tell you if the group policy is self-funded or was issued and delivered in another state. You should carefully read your certificate of coverage to learn more about continuation options. There are some important differences between Maryland law and COBRA.

To be eligible to continue coverage under Maryland law, you must meet the following requirements:

- Your spouse must be a resident of Maryland.
- Your spouse must be covered under a policy issued to an employer in Maryland.
- For the thirty days immediately preceding the divorce, you were covered as a spouse under the employer's group policy.

A dependent child of the insured is also eligible to continue coverage.

Your continuation coverage will be the same coverage available to other spouses covered under the group policy. You will need to pay the premium, including the portion usually paid by the employer for spouses. You and your spouse may agree on how to divide the premium payment between you, or it may be specified in a court order. There is no administrative fee under Maryland law, although there may be if you continue coverage under COBRA. You should carefully review your certificate of coverage for a detailed explanation of the continuation coverage available.

Maryland's continuation coverage for divorced spouses does not end after a specific time period. It does end when you become eligible for a group health benefit plan or Medicare, or become covered under an individual health policy. It will also end when you decide to remarry or decide to drop the coverage. If you have questions, ask your Human Resources department, or call us at (800) 492-6116.

CLAIMS ISSUES



CLAIMS ISSUES

Frequently Asked Questions:

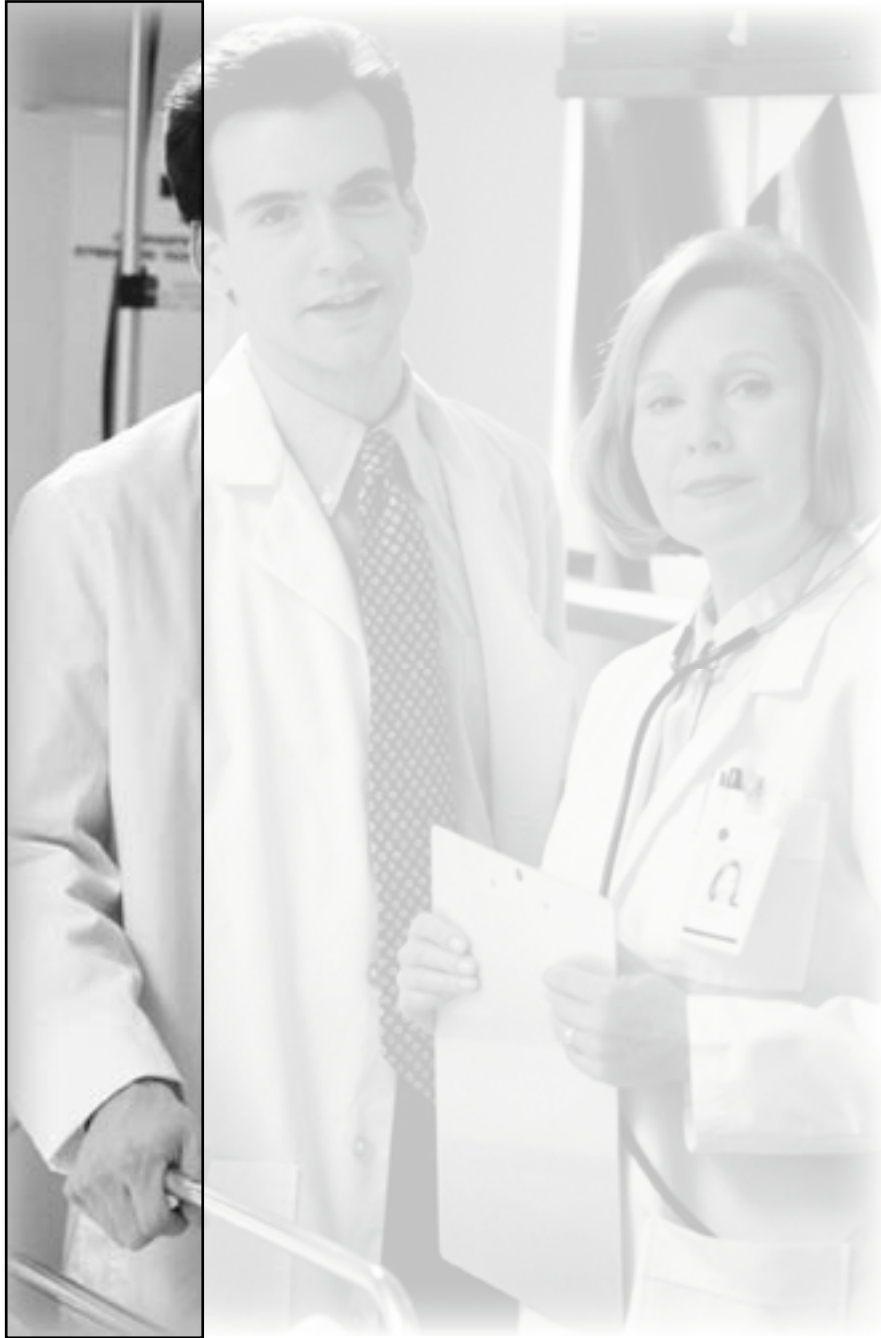
My Health Claim Was Denied. What Should I Do?

Health insurance and HMO claims may be denied for many reasons. Under Maryland law, the company is required to give you notice of the claim denial, including the reason the claim was denied. The notice should also explain how to appeal.

You should first file an appeal with the health plan. This is called an internal grievance. You should send a written appeal; a telephone call may not be enough. If your request for pre-authorization of services was denied, you have not yet received the services, and it is an emergency, you may request an expedited appeal. You may also receive an expedited appeal if your company says it is going to stop paying for services. You may also contact the Maryland Insurance Administration at (800) 492-6116 and we may be able to assist you. You should carefully review your certificate of coverage or policy and the denial notice that was sent to you to learn how to file an appeal. You should file your appeal as soon as possible. Your appeal may be denied by the health plan if it is past their deadline for appeals. The Health Education and Advocacy Unit in the Office of the Attorney General may assist you in preparing your internal grievance. Their toll-free telephone number is (877) 261-8807, and their web site is www.oag.state.md.us. (Complaint forms are available online.) If you are covered by a health insurance or HMO policy issued in Maryland, you only need to file one appeal with the company.

After you have received an appeal decision, if you remain dissatisfied, and your coverage is subject to Maryland law, you may file a complaint with the Maryland Insurance Administration. In some cases, you may be able to file a complaint regarding a denial based on medical necessity if you reside in Maryland, even if your policy was issued in another state. You may also file a complaint with the Insurance Administration if a claim is denied because your company states that the service is not covered by your policy. Our web site, www.mdinsurance.state.md.us has both complaint forms and authorizations to release medical records that you may print out and send to us. You should include copies of the denial letters you received from the company and any other correspondence you have. For further assistance, our toll-free number is (800) 492-6116.

DIRECTORY



DIRECTORY

State Agencies and Programs

Health Education and Advocacy Unit of the Attorney General's Office

The Health Education and Advocacy Unit ("HEAU") helps consumers resolve billing disputes with hospitals, doctors, insurance companies and other health care providers. The Unit also helps consumers negotiate refunds for medical equipment that is defective or was never delivered, and seeks repairs for medical equipment and other health care products. You may also contact the Unit if your insurance company refuses to pay or authorize services that it says are not medically necessary. The Unit will help you prepare an appeal of that decision. For more information about the services HEAU can provide to consumers, contact them at:

200 St. Paul Street
Baltimore, Maryland 21202
(410) 528-1840
(877) 261-8807
www.oag.state.md.us

Maryland Department of Aging

The Department of Aging provides information and assistance to Seniors about various services including insurance, long-term care, housing, health, nutrition, legal assistance and a variety of other topics that are of concern for Seniors. You can contact the Department of Aging at:

301 West Preston Street, Suite 1007
Baltimore Maryland 21201
(410) 767-1100
(800) 243-3425
(410) 333-7943 (fax)
www.mdoa.state.md.us

In addition to this State Agency, each locality has an Office of Aging which can assist Seniors obtain information about local programs:

Senior Health Insurance Assistance Program ("SHIP") – Provides assistance to individuals that have questions about their Medicare benefits. This program has trained individuals that can answer questions about benefits, billing and rights under the terms of the policy. Contact the SHIP office in your locality for assistance.

Long Term Care Ombudsman – Provides help to people that live in long term care facilities. Contact the Office of Aging in your locality to receive assistance.

Maryland Department of Disabilities

The Department of Disabilities evaluates programs and services for Maryland citizens with disabilities. The Department also helps Marylanders find public and private agencies that provide particular services. You can contact the Department at:

217 East Redwood Street, Suite 1300
Baltimore, Maryland 21202
(410) 767-3660 voice/TTY
(800) 637-4113 voice/TTY
www.mdtdap.org/oid.html

Maryland Department of Health and Mental Hygiene

The Department of Health and Mental Hygiene ("DHMH") oversees numerous boards, commissions and advisory groups relating to both private and public health issues. A full listing of the boards and commissions that DHMH oversees is available by contacting DHMH at:

201 West Preston Street
Baltimore, Maryland 21201
(410) 767-6860
(877) 463-3464
www.dhmh.state.md.us

The following is a limited listing of the offices within DHMH:

Office of Health Care Quality – Responsible for licensing and regulating hospitals and health-related institutions in Maryland. Investigates quality of care complaints filed against health maintenance organizations. You can contact them at:

Spring Grove Hospital Center
Bland Bryant Building
55 Wade Avenue
Catonsville, Maryland 21228
(410) 402-8000
(877) 402-8218

Health Professional Boards and Commissions – Various boards that oversee the licensing of health care providers including dentists and physicians. You can contact them at:

4201 Patterson Avenue
Baltimore, Maryland 21215
<http://www.dhmh.state.md.us/html/org-board&comm.htm>

Health Care Financing – Administers Maryland's medical programs including Medicaid and Maryland Children's Health Program. You can contact them at:

201 West Preston Street
Baltimore, Maryland 21201
(410) 767-4139

Maryland Health Care Commission ("MHCC") – Responsible for establishing quality and performance standards for HMOs, nursing homes, ambulatory surgery centers and hospitals. They are also responsible for developing a comprehensive standard health benefit plan and limited benefit plan for the small group market. You can contact them at:

4160 Patterson Avenue
Baltimore, Maryland 21215
(410) 764-3460
(877) 245-1762
www.mhcc.state.md.us

Health Services Cost Review Commission ("HSCRC") – Responsible for setting the rates that Maryland hospitals may charge. They also publish the "Consumer's Guide to Maryland Hospitals." You can contact them at:

4160 Patterson Avenue
Baltimore Maryland 21215
(410) 764-2605
(888) 287 – 3229
www.hscrc.state.md.us

Mental Hygiene Administration – Responsible for assisting people on Medicaid and people with limited incomes that are not on Medicaid obtain quality mental health care. You can contact them at:

Spring Grove Hospital Center
55 Wade Avenue
Dix Building
Catonsville, Maryland 21228
(410) 402-8300
(800) 735-2258 (TTY/MD Relay)

Maryland Medical Assistance Program – This program is responsible for providing access to health care services to low income residents of the State of Maryland. Services are provided through three programs – Maryland Medicaid Program, Maryland Children's Health Program and Maryland Pharmacy Assistance Program. To find out more information, contact your local Department of Social Services or your local Health Department. You may also contact the DHMH Recipient Relations Hotline at:

(410) 767-5800
(800) 492-5231
www.dhmf.state.md.us

Maryland Medicaid Waiver Program – This program is responsible for the implementation and ongoing administration of home and community-based services waivers and target case management programs for special population groups. The Program studies, plans, and implements services relating to the needs of special populations such as the elderly, the mentally ill, and all physically and mentally disabled. To learn more about what is available under this program, and whether you are eligible for any waivers, contact your local Department of Social Services.

The Maryland AIDS Administration – Dedicated to working with public and private partners to reduce the transmission of HIV, and help Marylanders already infected live longer and healthier lives. This is accomplished by promoting and developing comprehensive, compassionate and quality services, for both prevention and care. Programs supported by the AIDS Administration include education, prevention and social services. You can contact them at:

500 North Calvert Street, 5th Floor
Baltimore, Maryland 21202
(410) 767-5227
(800) 358-9001
webmaster@dhmf.state.md.us

Maryland Pharmacy Program – Maryland residents have several programs available to assist them to obtain prescription medication and supplies. To learn more about these programs, contact the Maryland Pharmacy Plan at:
P.O. Box 386

Baltimore, Maryland 21203-0386
(800) 226-2142
www.dhmf.state.md.us

Maryland Kidney Disease Program ("KDP") – Provides reimbursement for approved services required as a direct result of end-stage renal disease ("ESRD"). Applications may be obtained from the affiliated dialysis or transplant facility or by calling the Kidney Disease Program at (410) 767-5000. Completed applications and all required documentation should be submitted to the following address:

Kidney Disease Program of Maryland
201 West Preston Street, Room 314A
Baltimore, Maryland 21201

Maryland Worker's Compensation Commission

The Worker's Compensation Commission may be able to assist you if you are injured on the job or as a result of a job-related activity. If you have questions regarding your claim or benefits, you should contact the Commission at:

10 East Baltimore Street
Baltimore Maryland 21202
(410) 864-5100
(800) 492-0479
www.wcc.state.md.us

Maryland Department of Budget & Management – Office of Personnel Services and Benefits

State employees that have questions about their health benefits and their rights should contact the Employee Benefits Division at:

301 West Preston Street, Room 609
Baltimore, MD 21201
(410) 767-4775
(800) 30-STATE
(410) 767-4006 (TTY/TDD)
www.dbm.maryland.gov

Maryland Life & Health Insurance Guaranty Corporation

The Guaranty Corporation provides limited protection as set forth in the Maryland Guaranty Corporation Act to consumers who have policies or contracts with companies that are members of the Guaranty Corporation. To find out more information concerning the protections contact them at:

P.O. Box 671
Owings Mills, MD 21117
(410) 998-3907
(410) 998-3909 (fax)

Maryland Health Insurance Plan

Maryland Health Insurance Plan ("MHIP") is a state-administered health insurance program operated by an independent unit within the Maryland Insurance Administration. The plan is governed by a Board of Directors, consisting of public health care officials and a consumer representative. Maryland Physicians Care has been selected to administer the plan. To learn more about the plan, you can contact them at:

Maryland Physicians Care
7104 Ambassador Road
Baltimore, Maryland 21244
(866) 780-7105
www.marylandhealthinsuranceplan.state.md.us

Federal Agencies

Centers for Medicare & Medicaid Services

The Centers for Medicare & Medicaid Services ("CMS") is responsible for administering the Medicare program and working with the State to administer Medicaid, the State Children's Health Insurance Program, and the health insurance portability standards. You can contact them at:

7500 Security Boulevard
Baltimore MD 21244-1850
(410) 786-3000
(877) 267-2323
(866) 2226-1819 (TTY)
www.cms.hhs.gov
Medicare hotline – (800) MEDICARE

United States Department of Labor

If your employer provides health coverage through a self-insured plan, you should contact your employer to learn how to appeal any decision with which you disagree. If you still are not satisfied with the decision, you may contact the United States Department at:

1335 East-West Highway, Suite 200
Silver Spring, Maryland 20910
(301) 713-2000
(866) 444-3272
www.dol.gov/ebsa

Federal Employees Health Benefits Program

Federal employees that have completed their employers appeal process and would like the decision reviewed may contact the Office of Personnel Management at:

Office of Insurance Programs
1900 E Street, NW
Washington, DC 20415-1000
(202) 606-1800
www.opm.gov/insure/health/consumers/disputes.asp

Notes on Health Insurance Policies

Notes on Health Insurance Policies

This consumer's guide should be used for educational purposes only. It is not intended to provide legal advice or opinions regarding coverage under a specific insurance policy or contract; nor should it be construed as an endorsement of any product, service, person, or organization mentioned in this guide.

This document is available in an alternative format upon request from a qualified individual with a disability.



525 St. Paul Place
Baltimore, MD 21202
410-468-2000
1-800-492-6116
1-800-735-2258 TTY

www.mdinsurance.state.md.us

Robert L. Ehrlich, Jr.
Governor

Michael S. Steele
Lt. Governor

Alfred W. Redmer, Jr.
Commissioner

James V. McMahan, III
Deputy Commissioner